| IPDR6702 | | | | NORTH CAROLINA | | PAGE | : 1 | <u> </u> |
|----------|-----------------|-------------|-----------|---|----------------|------------------|---------------------|--|
| RUN DATE | : 03/06/2006 | | | RS CHECKWRITE SUMMARY REPORT CHECKWRITE DATE: 03/07/2006 | | | | |
| | | | | FINANCIAL PAYER: NCDMH | | | | |
| | | | | | | | | |
| PROVIDER | | HIGH DENIAL | NUMBER OF | | | | TOTAL | TOTAL |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | TNC DENIALS | TOTAL DENIALS | CLAIMS FINALIZED | CLAIMS PAID |
| | | | | | | | | |
| 3404901 | SMOKY MOUNTAINM | 8505 | 25 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | H/DD/SAS | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 8800 | 9 | FURTHER PROCESSING NECESSARY, | (| 34 | 34 | |
| | | | | PLEASE CHECK FOR CLAIM ON | | | | |
| | | | | FUTURE RA'S. | | | | - |
| 3404904 | WESTERN HIGHLAN | 8505 | 3172 | CLAIM DENIED DUE TO INSUFFICIE | | | | • |
| | DS LME | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 11 | 128 | CLIENT NOT ELIGIBLE ON SERVICE | | 3511 | 8237 | 472 |
| | | | | DATE | | | | |
| | | | | | | | | |
| | | 8621 | 68 | 60 RESIDENTIAL LEVEL III TREAT | | | | |
| | | | | MENT RECEIVED, PA IS REQUIRED | | | | † |
| | | | | FOR ADDITIONAL SERVICE. | | | | |
| 3404910 | | 8505 | 1710 | CLAIM DENIED DUE TO INSUFFICIE | | | | _ |
| _ 104510 | PATHWAYS | 3303 | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 9900 | 206 | ENDERGED DEOCESCING MEGRACIANY | | | | ļ |
| | | 8800 | 286 | FURTHER PROCESSING NECESSARY, PLEASE CHECK FOR CLAIM ON | | 2 2483 | 5611 | 312 |
| | | | 1 | FUTURE RA'S. | | | | |
| | | | | | | | | |
| | | 8534 | 203 | SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING | | | | |
| | | | | PROVIDER. PLEASE VERIFY THE F | | | | 1 |
| | | | | | | | | |
| 3404912 | CATAWBA COUNTYM | 8505 | 618 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | ENTAL HEALT | | | NT BUDGET | | | | - |
| | | | | | | | | |
| | | 11 | 34 | CLIENT NOT ELIGIBLE ON SERVICE | 3: | 735 | 1831 | 1096 |
| | | | | DATE | | | | ļ |
| | | | | | | | | + |
| | | 8931 | 17 | AMTNC INELIGIBLE TO RECEIVE SE | | | | |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| 3404913 | MECKLENBURG COM | 8599 | 51 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | ENTAL HEALT | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 8534 | 16 | SERVICE FACILITY LOCATION IS N | | 7 90 | 261 | 17: |
| | | | | OT A VALID IPRS ATTENDING | | 7 30 | 201 | 17. |
| | | | | PROVIDER. PLEASE VERIFY THE F | | | | |
| | | 143 | 10 | CLIENT ID NUMBER NOT ON STATE | | | | |
| | | 243 | 20 | ELIGIBILITY FILE | | | | - |
| | | | | | | | | |
| 24040** | | | | the No Dama to Direct | | | | |
| 3404916 | CROSSROADS BEHA | U | U | *** NO DATA TO REPORT *** | | | | - |
| | VIORAL HEAL | | | | | | | † |
| | | | | | | | | |
| | | 0 | 0 | | | 0 | 0 | |
| | | | | | | | | + |
| 3404917 | CENTERPOINT HUM | 11 | 452 | CLIENT NOT ELIGIBLE ON SERVICE | | | | † |
| | AN SERVICES | | | DATE | | | | |
| | | | | | | | | 1 |
| | | 79 | 393 | THIS SERVICE IS NOT PAYABLE TO | 1 | 7 1027 | 3583 | 255 |
| | | | | YOUR SUBMITTED BILLING | | 1027 | 5303 | 233 |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | ļ |
| | | 8599 | 84 | DETAIL NOT COVERED BY COMBINAT | | | | - |
| | + | | 1 | ION OF RECIPIENT, PROVIDER AND | | | | † |
| | | | | BENEFIT PACKAGE. | | | | |
| 24040** | | | | LLA VO DAMA TO DEPOSE | | | | |
| 3404918 | ROCKINGHAM CO M | U | U | *** NO DATA TO REPORT *** | | | | - |
| | ENTAL HEALT | | 1 | | | | | |
| | | | | | | | | |
| | | 0 | 0 | | | 0 | 0 | |
| | 1 | 1 | 1 | | 1 | | 1 | 1 |

| PROVIDER | 1 | HIGH DENIAL | NUMBER OF | | | | TOTAL | TOTAL |
|----------|-----------------|-------------|--|---|---------|---------|-----------|--------|
| NUMBER | | EOBS | DENIALS | DESCRIPTION | TNC | TOTAL | CLAIMS | CLAIMS |
| Addition | PROVIDER NAME | EUDS | DENTALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404919 | GUILFORD CO MEN | 8599 | 122 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | TAL HEALTHC | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | TAL REALING | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8931 | 43 | AMTNC INELIGIBLE TO RECEIVE SE | 51 | 261 | 4411 | 415 |
| | | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 5404 | 33 | SEVERE DUPLICATE: SAME ATTD PR | | | | |
| | | | | OV/PCODE/TOS/DOS/MOD | | | | |
| | | | | | | | | |
| 3404920 | | 0505 | 3635 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| 3404920 | ALAMANCE CASWEL | 8505 | 3633 | NT BUDGET | | | | |
| | L AREA MH D | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 8599 | 762 | DETAIL NOT COVERED BY COMBINAT | 58 | 6203 | 11232 | 502 |
| | | | - | ION OF RECIPIENT, PROVIDER AND | 30 | 0203 | 11232 | 302 |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8518 | 457 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
| | | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | | | | | | | |
| 3404921 | ORANGE PERSON C | 8505 | 2605 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | HATHAM AREA | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 0500 | 251 | DEFENSE NOT COMPAND BY COMPAND | | | | |
| | | 8599 | 351 | DETAIL NOT COVERED BY COMBINAT | 26 | 3425 | 6421 | 299 |
| | | | 1 | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | 8800 | 83 | FURTHER PROCESSING NECESSARY, | | | | |
| | | 0000 | 0.3 | PLEASE CHECK FOR CLAIM ON | | | | |
| | | | | FUTURE RA'S. | | | | |
| | | | | | | | | |
| 3404922 | THE DURHAM CENT | 8505 | 556 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | ER | | | NT BUDGET | | | | |
| | 221 | | | | | | | |
| | | | | | | | | |
| | | 8599 | 173 | DETAIL NOT COVERED BY COMBINAT | 5 | 1041 | 2188 | 114 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8535 | 152 | SERVICE FACILITY LOCATION WAS | | | | |
| | | | | NOT INCLUDED IN YOUR 837. | | | | |
| | | | | PLEASE RESUBMIT YOUR CLAIM WIT | | | | |
| 3404923 | | 0.1 | 680 | DUDY TOWN OF GUATH GUODDY | | | | |
| 3404923 | FIVE COUNTY MH | 21 | 660 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 256 | DETAIL NOT COVERED BY COMBINAT | 4 | 1299 | 10061 | 876: |
| | | | | ION OF RECIPIENT, PROVIDER AND | 4 | 1299 | 10001 | 070. |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 11 | 140 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |
| | | | | | | | | |
| | | | L | | | | | |
| 3404925 | SANDHILLS CENTE | 8505 | 1407 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | R FOR MH/DD | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 0500 | 100 | DEFENSE NOT COMPAND BY COMPAND | | | | |
| | | 8599 | 466 | DETAIL NOT COVERED BY COMBINAT | 116 | 3616 | 7764 | 414 |
| | | | 1 | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | - |
| | 1 | | - | DENELLI FACRAGE. | | | | |
| | | 21 | 453 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | + | 1 | + | | | | | - |
| | + | 1 | + | | 1 | | | |
| | | | | | | | | |
| 3404926 | SOUTHEASTERN RE | 8599 | 276 | DETAIL NOT COVERED BY COMBINAT | | | | |
| - | G MENTAL HL | | 1 | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | 1 | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 11 | 94 | CLIENT NOT ELIGIBLE ON SERVICE | 1 | 465 | 5199 | 473 |
| | | | | DATE | | | | |
| | | | | | | | | |
| | | | . — | | | | | 1 |
| | | | | | | | | |
| | | 191 | 48 | CLIENT ID NUMBER DOES NOT MATC | | | | |
| | | 191 | 48 | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME | | | | |

| | | | | | | | TOTAL | TOTAL |
|----------|----------------------------|-------------|-------------|--|---------|---------|-----------|----------|
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| | | | | | | | | |
| 3404927 | CUMBERLAND CO M | 8505 | 847 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| | HC | | | NT BUDGET | | | | |
| | | | | | | | | |
| | | 0500 | 4.50 | | | | | |
| | | 8599 | 159 | DETAIL NOT COVERED BY COMBINAT | 0 | 1390 | 3528 | 2138 |
| | | | | ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| - | | | | DENEFII FACAGE. | | | | |
| - | | 11 | 98 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | 11 | 30 | DATE | | | | |
| | | | - | M414 M | | | | |
| | | | - | | | | | |
| 3404929 | THE HARMES MILL | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | LEE HARNETT MH/ DD/SAS | | | | | | | |
| | DD/ SAS | | | | | | | |
| | | | | | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| | | | | | | Ü | · · | |
| | | | | | | | | |
| 3404930 | JOHNSTON COUNTY | 8599 | 193 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | MNTL HLTHC | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 8931 | 48 | AMTNC INELIGIBLE TO RECEIVE SE | 67 | 326 | 4173 | 3847 |
| | | | | RVICES IN IPRS. | 07 | 320 | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 10 | 20 | DIAGNOSIS OR SERVICE INVALID F | | | | |
| | | | | OR CLIENT AGE. VERIFY CID, | | | | |
| | | | | DIAGNOSIS, PROCEDURE CODE FOR | | | | |
| | | | | | | | | |
| 3404931 | WAKE CO HUM SVC | 21 | 590 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | BILLING OF | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | 8518 | 445 | CLAIM DENIED, SUBMITTED BEYOND | 109 | 1878 | 17085 | 15207 |
| | | | | FILING TIMELIMIT. PRIOR | | | | |
| | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | | | | | | | |
| | | 8599 | 218 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| 3404933 | SOUTHEASTERN CT | 8599 | 696 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | R FOR MH/DD | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 79 | 180 | THIS SERVICE IS NOT PAYABLE TO | 33 | 1017 | 5838 | 4821 |
| | | | | YOUR SUBMITTED BILLING | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | 0.004 | 0.5 | | | | | |
| | | 8621 | 25 | 60 RESIDENTIAL LEVEL III TREAT | | | | |
| | | | | MENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE. | | | | |
| | | | | FOR ADDITIONAL SERVICE. | | | | |
| 3404934 | OVOTOM 03 | 8599 | 215 | DETAIL NOT COVERED BY COMBINAT | | | | |
| J404534 | ONSLOW CARTERET | 0.333 | 215 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND | | | | - |
| - | BEHAV HEAL | + | 1 | BENEFIT PACKAGE. | | | | - |
| - | - | + | 1 | | | | | - |
| | | 11 | 211 | CLIENT NOT ELIGIBLE ON SERVICE | - | 2.1 | 0750 | 200 |
| | + | + | + | DATE | 6 | 744 | 2768 | 2024 |
| | - | | + | <u> </u> | | | | - |
| | + | | + | <u> </u> | | | | - |
| | | | | | | | 1 | — |
| | | 120 | 104 | CLIENT ID NUMBER MISSING OR IN | | | | |
| | | 120 | 104 | CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT | | | | |
| | | 120 | 104 | | | | | |
| | | 120 | 104 | VALID. ENTER CID AND SUBMIT | | | | |
| 3404935 | WAYNE CO MENTAI. | 120 | 0 | VALID. ENTER CID AND SUBMIT | | | | |
| 3404935 | WAYNE CO MENTAL HEALTH CTR | | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | | | | |
| 3404935 | | | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | | | | |
| 3404935 | | | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | | | | |
| 3404935 | | | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | 0 | 0 | 0 | 0 |
| 3404935 | | | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | 0 | 0 | 0 | 0 |
| | | 0 | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** | 0 | 0 | 0 | 0 |
| 3404935 | | | 0 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | 0 | 0 | 0 | 0 |
| | HEALTH CTR | 0 | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** | 0 | 0 | 0 | 0 |
| | HEALTH CTR | 0 | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** CLAIM DENIED DUE TO INSUFFICIE | 0 | 0 | 0 | 0 |
| | HEALTH CTR | 0 0 8505 | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** CLAIM DENIED DUE TO INSUFFICIE NT BUDGET | 0 | 0 | 0 | 0 |
| | HEALTH CTR | 0 | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT COVERED BY COMBINAT | 0 | 0 | 0 | |
| | HEALTH CTR | 0 0 8505 | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** CLAIM DENIED DUE TO INSUFFICIE NT SUDGET DETAIL NOT COVERED BY COMBINAT ION OF RECIFIENT, PROVIDER AND | 0 | | | |
| | HEALTH CTR | 0 0 8505 | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT COVERED BY COMBINAT | 0 | | | |
| | HEALTH CTR | 0 0 8505 | 0 0 500 226 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT GOVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 0 | | | |
| | HEALTH CTR | 0 0 8505 | 0 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. CLIENT NOT ELIGIBLE ON SERVICE | 0 | | | 1250 |
| | HEALTH CTR | 0 0 8505 | 0 0 500 226 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT GOVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 0 | | | |
| | HEALTH CTR | 0 0 8505 | 0 0 500 226 | VALID. ENTER CID AND SUBMIT AS A NEW CLAIM *** NO DATA TO REPORT *** CLAIM DENIED DUE TO INSUFFICIE NT BUDGET DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT FACKAGE. CLIENT NOT ELIGIBLE ON SERVICE | 5 | | | |

| April Apri | | | | | | | | | |
|--|----------|-------------------|--------------|-----------|--|---------|---------|-----------|----------|
| March Marc | PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | TOTAL | TOTAL |
| AND COLUMN CASE 1939 193 | | DROUIDER NAME | | | DESCRIPTION | | | | |
| ## 15 SECTION C. | | FROVIDER NAME | <u> </u> | | ** * | DENIALS | DENIALS | FINALIZED | PAID |
| ## PARTY S. FILES PRESENT PRODUCT PROSE FILES PRESENT PRODUCT PROSE FILES PRESENT PRODUCT PROSE FILES PRESENT PRODUCT PROSE FILES PRESENT FILES PRESENT FILES FILES PRESENT | 3404937 | EDGECOMBE NASH | 8518 | 771 | CLAIM DENIED, SUBMITTED BEYOND | | | | |
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| | | | | | FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| 10 10 10 10 10 10 10 10 | | | | | | | | | |
| | | | 8599 | 131 | DETAIL NOT COVERED BY COMBINAT | 0 | 964 | 2713 | 1749 |
| 10 10 10 10 10 10 10 10 | | | | | | | | | |
| | | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | | |
| 1005 CORRESS | | | 21 | 42 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| 1005 CORRESS | | | | | | | | | |
| 1005 CORRESS | | | | | | | | | |
| 1005 CORRESS | | | | | | | | | |
| 104159 9 1 1 1 1 1 1 1 1 | | | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| 1000000 | | TONE COUNSE | | | | | | | |
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| APPEN CONTINUES 1999 15 | | | 0 | · | | 0 | 0 | 0 | 0 |
| APPEN CONTINUES 1999 15 | | | | | | | | | |
| APPEN CONTINUES 1999 15 | 3404939 | VIDIOR VIDIOR VID | 8505 | 78 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
| 1999 19 | | | | | | | | | |
| | | ALTH CENTER | | | | | | | |
| | | | 1 | | | | | | |
| DECEMBER | | | 8599 | 35 | DETAIL NOT COVERED BY COMBINAT | n | 155 | 1825 | 1670 |
| | | | 1 | | ION OF RECIPIENT, PROVIDER AND | Ů | 133 | 1023 | 2070 |
| 1459911 PITT CO MATRICAL 1559 145 DEPAIL BY COMPAND BY C | | | 1 | | | | | | |
| 1459911 PITT CO MATRICAL 1559 145 DEPAIL BY COMPAND BY C | | | İ | | | | | | |
| 100 OF PRICESSENS AND 101 | | | 21 | 35 | DUPLICATE OF CLAIM-SYSTEM | | | | |
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| 100 OF PRICESSENS AND 101 | | | | | | | | | |
| 100 OF PRICESSENS AND 101 | | | | | | | | | |
| ACCUSTER ACCUST | 3404941 | PITT CO MH/DD/S | 8599 | 145 | | | | | |
| 131 40 CLIENT ID MOMERN DOES NOT MATC 2 237 2254 | | | | | | | | | |
| | | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | | |
| 100 | | | 191 | 40 | | 2 | 257 | 2254 | 1997 |
| 100 | | | | | H PATIENT NAME | | | | |
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| 100 | | | 27 | 20 | DIACMOSTS CODE MISSING OR IMVA | | | | |
| | | | 21 | 20 | | | | | |
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| 100 OF PRICEERING, PROVIDER AND 1 72 1550 | | | | | CORRECT DIAGNOSIS CODE AND SUB | | | | |
| 100 OF PRICEERING, PROVIDER AND 1 72 1550 | 3404942 | | 8599 | 25 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | | | | | | |
| 1 | | UMAN SERVIC | | | | | | | |
| 1 | | | | | | | | | |
| 1 | | | 21 | 14 | DUPLICATE OF CLAIM-SYSTEM | 1 | 72 | 1550 | 1478 |
| ALBEMARIE MENTA 8931 52 ANTIC INCLIDENCE SE 3040443 ALBEMARIE MENTA 8931 52 ANTIC INCLIDENCE SE 87/CES IN 1978. 1 HEALTH CE | | | | | | _ | 7.2 | 1330 | 1470 |
| ALBEMARIE MENTA 8931 52 ANTIC INCLIDENCE SE 3040443 ALBEMARIE MENTA 8931 52 ANTIC INCLIDENCE SE 87/CES IN 1978. 1 HEALTH CE | | | | | | | | | |
| ALBEMARIE MENTA 8931 52 ANTIC INCLIDENCE SE 3040443 ALBEMARIE MENTA 8931 52 ANTIC INCLIDENCE SE 87/CES IN 1978. 1 HEALTH CE | | | | | | | | | |
| 1404943 ALBEMARLE MENTA 8931 52 AMINC INELIGIBLE TO RECEIVE SE | | | 11 | 13 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| L HEALTH CE 1 | | | | | DATE | | | | |
| L HEALTH CE 1 | | | | | | | | | |
| L HEALTH CE 1 | | | | | | | | | |
| 79 32 THIS SERVICE IS NOT PAYABLE TO 73 171 1617 YOUR SUBMITTED BILLING 7 73 171 1617 YOUR SUBMITTED BILLING 7 73 171 1617 PROVIDER TYPE AND SPECIALTY IN 7 7 7 7 7 7 7 7 1 7 1 1617 SEMENT PACKAGE. 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 | 3404943 | ALBEMARLE MENTA | 8931 | 52 | | | | | |
| 1 | - | | | | RVICES IN IPRS. | | | | |
| YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN 8599 22 DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. 3404944 EASTPOINTE HUMA 79 354 THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN 8599 540 DETAIL NOT COVERED BY COMBINAT 44 2111 4344 ION OF RECIPIENT, PROVIDER AND SENEFIT PACKAGE. 8536 111 ATTENDING PROVIDER TYPE AND SP CICALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR 4404946 FOOTHILLS AREAM 8599 540 DETAIL NOT COVERED BY COMBINAT 100 OF RECIPIENT, PROVIDER TYPE AND SP 101 102 103 103 104 105 105 105 105 105 105 105 105 105 105 | | | | | | | | | |
| YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN 8599 22 DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. 3404944 EASTPOINTE HUMA 79 354 THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN 8599 540 DETAIL NOT COVERED BY COMBINAT 44 2111 4344 ION OF RECIPIENT, PROVIDER AND SENEFIT PACKAGE. 8536 111 ATTENDING PROVIDER TYPE AND SP CICALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR 4404946 FOOTHILLS AREAM 8599 540 DETAIL NOT COVERED BY COMBINAT 100 OF RECIPIENT, PROVIDER TYPE AND SP 101 102 103 103 104 105 105 105 105 105 105 105 105 105 105 | | | 70 | | | | | | |
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| CIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING FR SAMPHAGE FOOTHILLS AREAM SSSS SAMPHAGE ENTAL HEALT INCOME PRECIPIENT, PROVIDER AND SENEFIT PACKAGE. LILIANT NOT ELIGIBLE ON SERVICE GATE GATE GATE DATE | | | | | | | | | |
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| 3404957 | TIDELAND MENTAL | 8599 | 286 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | HEALTH CTR | | | ION OF RECIPIENT, PROVIDER AND | | | | |
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| | | 79 | 51 | THIS SERVICE IS NOT PAYABLE TO | | | | |
| | | | | YOUR SUBMITTED BILLING | | | | |
| | | | | PROVIDER TYPE AND SPECIALTY IN | | | | |
| 3404979 | NEW RIVER AREAM | 8505 | 2988 | CLAIM DENIED DUE TO INSUFFICIE | | | | |
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| | | 11 | 192 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | | | | DATE | | | | |